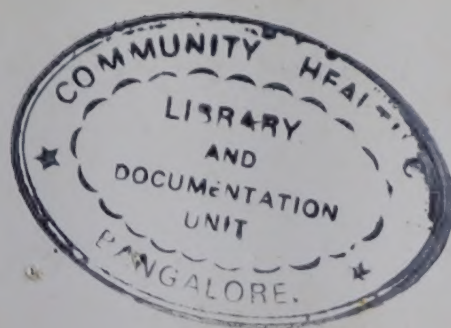


ACTIONAID



Small is Practical

A Study of Family Planning Experiences
of Rural Development Trust, Anantapur

LEARNING FROM EXPERIENCE SERIES - 3

Giving
People
Choices



385

With Compliments

Binu. S. Thomas
Coordinator,
Policy Unit.

Giving
People
Choices



ACTIONAID

3 Rest House Road Bangalore 560 001 INDIA Tel : 5586682 Telex : 0845 2142 Fax : 080 5586284

Community Health Cell
y and Documentation Unit
ALORE

03247

SMALL IS PRACTICAL

COMMUNITY HEALTH CELL

I Block K...

**A STUDY OF FAMILY PLANNING EXPERIENCES OF
RURAL DEVELOPMENT TRUST, ANANTAPUR**

BY

**THE POLICY UNIT
ACTIONAID INDIA**

SEPTEMBER 1994

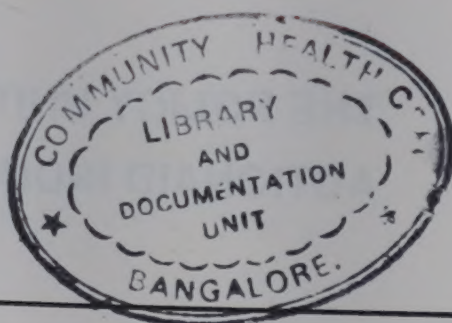
ACKNOWLEDGEMENTS

This study is a joint initiative of the Rural Development Trust, Anantapur, and the Policy Unit, ACTIONAID India. A number of people from both organisations have helped shape it. Thanks to Anne Ferrer, Deena Kumari, Dr V. Janardhana Rao, Dr C. Hari Narayana Rao, M. Murali Mohan Reddy, R. Dasarath and the field staff of RDT who gave of their time and expertise; to Salil Shetty, Dr. Anthony Colaco and Dr. Nigel Padfield from ACTIONAID for their critical inputs. Much of the coordination of the study, the data analysis and writing up was the work of Bhuvana Krishnan from the Policy Unit with assistance from C. Upendranadh.

Several external contributions/comments are gratefully acknowledged. Our thanks to Mrs Ann Marsden, Mrs Rani Coelho, Ms Cynthia Stephen, Mr. As Mohammad, Dr Devadasan and Dr. H. Van Balen.

This study would not have been possible but for the numerous women who shared their experiences and understanding on this rather personal subject. Our thanks to them. Finally we would like to acknowledge the cooperation and support received from local government officials.

Coordinator
Policy Unit



Published by:

The Policy Unit
ACTIONAID India
3 Rest House Road
Bangalore 560 001
Ph : 5586682
Fax : 5586284

Portions of this document may be freely reproduced with the source acknowledged.

TABLE OF CONTENTS

	LIST OF FIGURES AND TABLES	(i)
	EXECUTIVE SUMMARY	1
CHAPTER I	INTRODUCTION	5
CHAPTER II	AIMS, OBJECTIVES & METHODOLOGY	7
CHAPTER III	RDT'S FAMILY PLANNING SERVICES	9
	The Project and the Area	
	Family Planning Services	
	Grass-root Motivation	
	Staff, Facilities and Services	
	Incentives and Costs	
	Collaboration with Government Services	
CHAPTER IV	FINDINGS & DISCUSSION	15
	Trends in Usage	
	Profile of Acceptors	
	Influence of Caste, Education and Occupation	
	Knowledge and Usage of Family Planning	
	Decision to Have a Tubectomy	
	Desire for a Son and Ideal Number of Children	
	Decision to Use RDT Facilities	
	Limitations of the Study	
CHAPTER V	CONCLUSIONS & RECOMMENDATIONS	33
	ANNEXURE	35
	REFERENCES	41

LIST OF FIGURES AND TABLES

Figure/Table	
Fig 1	Number of acceptors, 1988-92
Annex-Tbl 1	Number of acceptors, 1988-92
Table 1	RDT's share of sterilisations performed in Anantapur District, 1988-93
Fig 2	Distribution of acceptors by no. of children 1988, 92, 93
Annex-Tbl 2	Distribution of acceptors by no. of children 1988, 92, 93
Fig 3	Mean number of children of acceptors, 1988-93
Annex-Tbl 3	Mean number of children of acceptors, 1988-93
Table 2	Distribution of acceptors by caste, 1988, 92, 93
Table 3	Distribution of acceptors by education, 1988, 92, 93
Fig 4	Mean no. of children by caste of acceptors, 1988 & 92
Annex-Tbl 4	Mean no. of children by caste of acceptors, 1988 & 92
Table 4	Mean no. of children by caste of acceptors, 1993
Annex-Tbl 5	Distribution of acceptors by caste and no. of children, 1988-92
Annex-Tbl 6	Distribution of acceptors by caste and no. of children, 1993
Fig 5	Mean age of acceptors by caste, 1988 & 92
Annex-Tbl 7	Mean age of acceptors by caste, 1988 & 92
Table 5	Mean age at marriage & operation by caste of acceptor, 1993
Annex-Tbl 8	Distribution of acceptors by education of acceptor & spouse and no. of children, 1988-92
Annex-Tbl 9	Distribution of acceptors by education of both acceptor & spouse and no. of children, 1988-92
Annex-Tbl 10	Distribution of acceptors by education of acceptor & spouse and no. of children, 1993

Figure/Table

Annex-Tbl 11	Distribution of acceptors by education of both acceptor & spouse and no. of children, 1993
Fig 6	Mean no. of children by education of acceptor, 1988 & 1992
Annex-Tbl 12	Mean no. of children by education of acceptor, 1988 & 1992
Table 6	Mean no. of children by education of acceptor, 1993
Table 7	Mean no. of children by education of both acceptor & spouse, 1988-92
Fig 7	Mean age of acceptors by education, 1988 & 92
Annex-Tbl 13	Mean age of acceptors by education, 1988 & 92
Table 8	Mean age at marriage and operation by education of acceptor, 1993
Table 9	Mean no. of children by occupation of acceptors, 1993
Table 10	Knowledge and usage of FP among acceptors, 1993
Table 11	Knowledge and usage of FP among non-acceptors, 1993
Table 12	Acceptors without a son/daughter by caste, 1988 & 1992
Table 13	Acceptors without a son/daughter by no. of children, 1988-92
Fig 8	Distribution of acceptors & non-acceptors by opinion on ideal no. of male/female children, 1993
Annex-Tbl 14	Distribution of acceptors & non-acceptors by opinion on ideal no. of children, 1993
Table 14	Source of knowledge about RDT FP facilities, 1993
Table 15	Reasons for using RDT FP facilities, 1993
Table 16	Acceptors' perception of RDT facilities, 1993

EXECUTIVE SUMMARY

Introduction

Rural Development Trust (RDT), an ACTIONAID-supported NGO has been working with the most backward communities of Anantapur district in Andhra Pradesh since 1969. Over 250 villages are covered under an integrated development programme, targeting the poorest, mainly those from the Scheduled Castes (SCs), Scheduled Tribes (STs) and Backward Castes (BCs), who form over 80% of the population in the district. Since 1987-88, as part of its comprehensive health programme, RDT has been providing family planning (FP) services - mainly female sterilisation - through two health centres (Kalyandurg, Kuderu), with a third centre (exclusively for FP) being set up in 1989 in Anantapur town at the request of the district health authorities.

The aim of this study is to document RDT's experience and examine the factors influencing FP usage. This is done by analysing data from RDT case records of over 12000 women who attended its FP camps over five years (1988-92), and the results of surveys conducted in 1993 of acceptors (104) and non-acceptors (99) in the RDT project area. Direct observation/participation and discussions with project and government staff, and women and their families have also formed part of the study methodology.

Findings

Trends in Usage

- The number of tubectomy acceptors in the three RDT centres increased more than threefold, from 1092 (1988) to 3777 (1992).
- The rate of increase in sterilisations performed in RDT centres was considerably higher than in the entire district. RDT's share in the district total increased from 10% to 18% between 1989-93.
- The Couple Protection Rate (CPR) by permanent methods was higher in RDT project villages (43% as compared to 37% in the district as of end June 1993).

Profile of Acceptors

- There has been a marked decrease in the mean age and parity (number of live births per tubectomy acceptor) among RDT acceptors :

1988	-	27.4 years (age) and 3.36 (parity)
1992	-	26.7 years (age) and 3.14 (parity)
1993 (survey)	-	23.8 years (age) and 2.94 (parity)

The mean age was lower than the state/all India figures, while mean parity appeared to be nearing these levels.

- The overall socio-economic profile (caste, education, occupation) of acceptors generally reflected that of the population in the RDT project and catchment areas:
 - The majority of acceptors were BCs (as in the overall population), followed by the Forward Castes (FCs), the SCs and STs (1988,92 and 93).
 - Most acceptors (more than 80%) were illiterate (considerably higher than the national average).
 - The majority (53%) were small and marginal farmers or landless labourers.

Factors Influencing Age and Parity

- Mean age and parity fell among all castes and at all education levels between 1988-92.
- Mean age and parity were found to be associated with caste and education of acceptors over the five year period (1988-92). The importance of the acceptor's (wife's) education on family size was clearly evident.
- In the 1993 survey, there seemed to be a general move towards smaller family size (3 or less) and lower age among acceptors from all castes and at all education levels.

Knowledge, Usage and Attitudes

- Both knowledge and usage of temporary FP methods were found to be higher among non-acceptors (women with four or more children who have not had tubectomies) as compared to acceptors. Vasectomy was generally rejected by the women as harmful to the husband's health.
- The decision to have a tubectomy was most often a joint decision, or made by the spouse (husband) alone or by close relatives.
- Among acceptors, the two main reasons for accepting sterilisation were that they could take better care of their children and that they had enough sons (or did not want another daughter).
- Conversely, the main reason for non-acceptance was waiting for a son, followed by fear of the operation itself. Fear about survival of children was not a major reason.
- A little less than half of non-acceptors were actually potential acceptors who had delayed having a tubectomy because of waiting for a son.

- The desire for a son was reflected in almost every aspect of the data:
 - Acceptors without a daughter were more than four times as many as those without a son (1988 and 92).
 - Among acceptors with two children or less (1988-92), 43% had no daughter, as compared to only 6% without a son.
- The majority of acceptors (60%) felt that two children (1Male+1Female) was the ideal family size, while, among non-acceptors, an equal number (38% each) opted for two (1M+1F) and three (2M+1F) children as the ideal.
- In the case of both (acceptors and non-acceptors), there was no 'ideal' combination (M+F) without at least one son.
- Most acceptors (more than 90%) mentioned good treatment/facilities and confidence in RDT services as their reason for using RDT facilities.
- Acceptors' willingness to travel long distances to RDT centres (mean distance traveled was 23 km) indicated that accessibility was not a major constraining factor.
- Incentives were found not to be a major factor influencing the decision to have a tubectomy.

Conclusions and Recommendations

- Quality of service seems to be the key to increasing FP usage among the community. While accessibility is important, quality of care, treatment and facilities is perceived as even more so. Greater emphasis needs, therefore, to be placed on improving and upgrading existing FP facilities.
- The consistent decrease in mean parity among all castes and at all education levels indicates the increasing acceptance of the small family norm.
- The increasingly young age of acceptors is more a matter of concern than a positive sign, since, given the early age at marriage and the poor use of spacing methods, in practice most acceptors have already completed desired family size.
- The fact that women perceive sterilisation as the only method (which is safe, effective and available) perhaps indicates a lack of real alternatives. More concerted efforts need to be made to promote temporary FP methods. But this can only be achieved as part of a holistic approach which aims at improving the overall health of women, raising the age at marriage and changing attitudes and perceptions in the community.
- Greater efforts need to be made to change existing perceptions and attitudes towards vasectomy and more effectively involve men in the FP programme.

- The gap between ideal and actual family size is largely related to the desire for a son, indicating the need for an integrated approach which aims at raising education and awareness levels, and empowering women, rather than on focussing on FP alone.
 - While existing incentives in the form of compensation are perceived as a right by acceptors, the role of incentives in general, and the rationale for giving them, needs to be re-examined.
 - An issue that RDT also needs to examine in the near future is the cost-effectiveness of its FP programme.
-

SMALL IS PRACTICAL

CHAPTER I

INTRODUCTION

India's growing population (2.14% growth p.a between 1981-91) is constantly outstripping the capacity of the country to meet its development goals. The containment of population growth is, therefore, viewed as being critical for the success of all development efforts, and forms one of the six most important objectives of the Government of India's Eighth Five-Year Plan (1992-97).

The need to focus on this problematic area has been recognised in successive plans. In fact, India was the first country in the world to launch a nation-wide family planning programme as far back as 1952, and the Third Five-Year Plan (1961-66) viewed it as "the very centre of planned development". Promotion of family planning on a purely voluntary basis and the broadening of the focus to encompass family welfare occurred in the late seventies. In the eighties, the objective was to promote the acceptance of the "small family norm" to stabilise the country's population in order to improve the quality of life of the people.

However in spite of the concerted and prolonged effort to contain population growth and vast sums being expended for this purpose (the allocations have increased over ten thousand times from Rs 6.5 million in the First Plan to Rs 65,000 million in the Eighth Plan), the results in containing population growth have been generally unsatisfactory, with constant postponement and revision of targets. Some of the factors held responsible for this poor performance are:

- Lack of an effective strategy/programme which focuses not just on couple protection, but also recognises the importance of social factors such as female literacy, age at marriage and status of women and adopts a multi-pronged integrated approach.
- Centralised planning and top-down target setting which do not allow for differing regional requirements.
- Lack of active involvement and participation of the community.
- Inadequate outreach and poor quality of family planning services.
- Ineffectiveness of the present system of incentives and awards.

In the Eighth Plan period, the Government's strategy aims at a more holistic and

decentralised approach, with mass involvement. Towards this end, a New Population Policy is being formulated.

Non-governmental organisations (NGOs) have played a major role in assisting the government in implementation of the programme, especially at the grass-roots level. The Eighth Plan Document views the role of NGOs as critical for generating momentum and accelerating the pace of progress in building up a mass movement for population control. It argues that family planning should be incorporated as a major objective of all NGOs involved in health/education activities. It also visualises an increasing amount of funds being channelised through NGOs, and recommends the setting up of an apex organisation to coordinate their work in this area.

This study looks at the experience of one such NGO - the Rural Development Trust, Anantapur - and tries to describe and analyse some of the trends emerging over the five-year-period during which it has been providing family planning services as part of its larger, integrated, poverty eradication programme. A more immediate reason for undertaking this study has been the rapid rise in the number of women (3777 in 1992 compared to 1092 in 1988) availing family planning services in RDT, and the need to understand the trends emerging as a basis for planning the future development of the programme.

The timing of the study is appropriate. The International Conference on Population and Development (ICPD) in Cairo this month will focus global attention on several issues highlighted here — issues such as female literacy, early marriages, low status of girls, etc., and the influence these have on family size. It is to be hoped that the ICPD will go beyond mere platitudes and recommending top-down solutions to initiate a genuine bottom-up process that would give primacy to people who matter most — the parents of today and tomorrow.

CHAPTER II

AIM, OBJECTIVES, METHODOLOGY

Aim & Objectives

The aim of the study is to examine RDT's experience with regard to the delivery and usage of its family planning services. This would serve as a learning for the NGO and for others involved in family planning programmes. The specific objectives of the study are:

- To describe the operational aspects of provision of family planning services by RDT and its collaboration with the government health services.
- To study the trends with regard to usage of permanent family planning methods (tubectomy) in RDT centres.
- To study the characteristics of tubectomy acceptors in RDT centres.
- To examine the influence of factors such as caste and education on family size.
- To assess knowledge and usage of family planning methods among acceptors and non-acceptors, and their perceptions/attitudes with regard to:
 - decision-making about family planning
 - RDT facilities/services
 - ideal number of children.

Methodology

The study is both descriptive and analytical. Chapter III examines RDT family planning services and describes their provision, largely based on direct observation/participation and discussions with RDT and government staff, community health workers, and acceptors/non-acceptors and their families. Chapter IV sets out the findings of the study, based on analysis of RDT and government records and survey findings. These are discussed, and inferences made based on these findings. Finally, in Chapter V, some of the emerging issues are summarised.

Project and Government Records

RDT family planning records (case sheets) from the three centres for the five-year-period 1988-92 were analysed to build up a profile of acceptors, derive trends in usage and examine the influence of caste and education on family size. Data on usage of permanent family planning methods and couple protection rates was obtained from government records.

Sample Survey of Acceptors and Non-Acceptors

A survey of acceptors in the three centres was conducted in August-September 1993, in order to collect data on the profile and perceptions/attitudes of acceptors. During the course of the study, it was decided to broaden its scope to cover non-acceptors. A similar survey was undertaken of non-acceptors, defined as women who have not undergone tubectomy and having four or more living children, with the last child being more than one year old. A few case studies were also conducted.

Sample Selection

The sample size initially selected was 100 acceptors (about one-third the total monthly average in 1992), distributed evenly across the three centres in order to permit comparisons. While month-wise data on number of acceptors in 1992 showed some seasonal fluctuation, it was felt that a cross-sectional survey would provide representative data, as RDT experience shows that there is no major variation in characteristics of acceptors over the year or in different centres.

A complete enumeration of acceptors attending the weekly camp was done in Kuderu and Kalyandurg. In Anantapur, enumeration of acceptors was carried out in one ward (out of a total of three wards at the centre). The final sample was 104 acceptors: Kalyandurg (38), Anantapur (34) and Kuderu (32). A matching random sample of 99 non-acceptors from 50 villages was used for the survey of non-acceptors.

Questionnaire

A largely structured questionnaire was used, which was field-tested with 15 acceptors attending camps in Anantapur and Kuderu, and after necessary modifications, administered in the local language by a survey team comprising RDT staff and resource persons from local NGOs. The team included both men and women, but the questions relating to knowledge and usage of family planning methods were administered by women. A similar questionnaire was used for non-acceptors with suitable modifications.

CHAPTER III

RDT'S FAMILY PLANNING SERVICES

The NGO and the Area

RDT's target families are mainly from among the Scheduled Castes (SCs), Scheduled Tribes (STs) and the Backward Castes (BCs), who form 16%, 4% and approximately 60%, respectively, of the rural population in the district. Dryland farming, mainly groundnut in red soils, and small livestock breeding are the chief sources of livelihood. Literacy rates in the district are low: 21% among rural women and 51% among rural men (1991 Census).

RDT was founded by Vincent Ferrer, with the main aim of bringing about a sustainable improvement in the economic and social condition of the poorest and most socially disadvantaged people of Anantapur district in the drought-prone Rayalseema region of South Western Andhra Pradesh. Beginning with major food-for-work programmes, the NGO had, by the late seventies, moved to an integrated approach with major programmes in the areas of community organisation (men and women), community health, education and ecology development. The target population is around 49,000 SC, ST and BC families (out of a total population of around 85,000 families) in 265 villages. The health programme, however, is not restricted to target families alone, but can be accessed by the community in general. The 265 villages covered are functionally grouped into six areas (Kalyandurg, Atmakur, Kuderu, Kundurpi, Kambadur, Settur) comprising 12 units of 18-20 villages each, spread across Kambadur, Kalyandurg, Kuderu and Urvakonda blocks of Anantapur district. More recently, the project has started work in 35 villages of Dharmavaram block in the same district. RDT has a central campus located in Anantapur town and a total staff of 750 spread across the target area.

History of RDT's Family Planning Programme

In the early eighties, RDT had no direct intervention in the area of family planning as it was felt that this was a major thrust area of the government health programme and it would be better for RDT to concentrate its efforts in other areas. In subsequent years, as RDT took up a more comprehensive health programme, with Community Health Workers (CHWs) in each village providing mother and child care, it was felt that family planning should also be taken up as an integral part of this programme. Anantapur district rates among the lowest in the state in terms of family planning performance and has a higher than average population growth rate — 2.23% p.a. as compared to 2.17% p.a. for the state as whole during 1981 - 91.

Beginning in 1987-88, RDT started providing family planning services through its health centre in Kalyandurg. Initially, the cases covered were included under the government Primary Health Centre (PHC) in nearby Beluguppa, which meant that even though tubectomies were performed by RDT doctors, only the government doctor could sign for them. RDT, therefore, sought and achieved recognition under the government's Private Practitioner Scheme. In 1988, family planning services were started in the Kuderu health centre and in 1989, at the request of the district medical authorities, a centre was set up in Anantapur town in order to improve existing services which were felt to be inadequate to meet the demands of the town's two hundred thousand odd population.

The centres in Kalyandurg and Kuderu provide general medical services, in addition to family planning services, while the Anantapur centre is exclusively devoted to family planning. Usage of temporary family planning methods is negligible, as is the number of male acceptors of vasectomy (less than five in the last five years). Family planning is, therefore, as in most of the country, largely confined to voluntary female sterilisation, with tubectomy as the preferred method. During the last five years (1988-92) over 12,000 tubectomies have been done in RDT's three centres, with the numbers increasing every year (4581 in 1993). Anantapur has catered largely to people from outside the RDT project area, while in Kalyandurg over 75% were from project villages, and in Kuderu they were about evenly divided.

Grass-Roots Level Motivation

RDT's community health programme was started with the broad objective of "...bringing health care to the people within walking distance, if possible, through local trained persons." Initially, young men from the area were selected and trained to act as a training team for village workers; subsequently, young married women, generally illiterate, from amongst the target community were selected to work as community health workers (CHWs) on a part time basis, receiving an incentive of Rs.150/month. This incentive was gradually withdrawn and, at present, out of the 200 or so CHWs (one in each village), more than half are working without incentives from RDT, receiving payment in kind from the community.

Initially, RDT's intervention was largely in the area of motivating couples to accept the 'small family' norm and adopt family planning, with the CHWs as the prime motivators at the grass-root level. (RDT's definition of the small family - unlike the government's - extends up to three children, because child survival is still an area of concern for the NGO.) CHWs worked in close cooperation with the government multipurpose health workers (MPHWs) who found that the CHWs' knowledge and influence in the community were useful in helping motivate people to come forward for family planning.

At the same time, this created a certain amount of conflict as the MPHWs felt that the CHWs were taking cases away from them, thus making it more difficult for them to achieve their individual targets. Also, the number of cases approaching RDT centres (brought in by government and RDT workers) started increasing, and the emphasis, therefore, gradually shifted from motivation to providing services. The majority of government MPHWs preferred to bring their cases to RDT because of the quality of service provided, and felt more comfortable with RDT as it concentrated on services rather than on target achievement. Motivation, however, continued to be a part of the CHW's work, although the cases motivated by them and other RDT staff are officially claimed by the MPHWs.

Staff, Facilities and Services

Kalyandurg and Kuderu are referral centres, with X-ray and lab facilities, providing general medical care (both out-patient and in-patient) in addition to FP services. They each have around 50 beds - 25 reserved for FP cases. Kalyandurg has a daily average of around 100 out-patients, while Kuderu has 60. Both centres have regular medical and nursing staff for FP ward work, theatre and out-patient care. Anantapur has 60 beds and caters only to FP cases. It has only a manager and assistant as permanent staff. On days when patients are admitted and operations performed, medical and nursing staff are deputed from Kuderu and the government also provides a doctor and nurse for additional support.

Operations are performed (in camps) on different days in each centre, once a week in Kuderu and twice a week in the other two centres. The average number of women per camp is around 16-20 in Kuderu and Kalyandurg and 60 in Anantapur. Patients are examined clinically at the time of admission to ensure that they are fit. Laboratory tests including blood, haemoglobin level estimation and urine tests for albumin and sugar are carried out. Patients are admitted a day before the operation and are kept for seven days after, until the sutures are removed. Food and treatment are provided free, including antibiotics and vitamins in the post-operative period. Husbands generally accompany their wives when they arrive but do not stay. An attendant, usually the patient's mother, mother-in-law or grandmother, remains to look after her and, more importantly, her infant, since the majority (93%) come within one month of delivery. Attendants are expected to make their own provisions for food, although space is provided for them to cook their meals.

The major difference between the government PHCs/hospitals and RDT centres is that, in the former, patients normally go home within 24 hours of the operation, out of preference or because there are no facilities for keeping them overnight. In RDT they stay for seven days until the sutures are removed.

Permanent Methods

Tubectomy, which is the generally used method both in government and RDT centres, requires seven days' post-operative care, while laparoscopy needs only a day. However,

the latter procedure requires skilled medical staff and women are generally not in favour of it - in fact, they express a positive preference for tubectomy, even though many would prefer to go home within 24 hours. The button-hole procedure is a little less invasive as compared to laparoscopy, and, therefore, more acceptable to women. It is also quicker and women need spend only a few hours. Recently, this procedure is becoming increasingly popular in Anantapur, and, unlike regular tubectomy, it is mostly performed after the post-natal period.

Temporary Methods

When RDT started providing family planning services, both temporary and permanent methods were considered. It was felt that among the temporary family planning methods, the IUD was likely to be the most popular among the community, as against the condom or the oral pill. Several RDT health workers were trained in this method by government staff. The retention rate was, however, found to be extremely low: four out of seven women wanted it removed within a few weeks, complaining about bleeding, pain or sexual discomfort. At the same time the number of tubectomy acceptors kept increasing. The programme, therefore, became increasingly focused on tubectomy as the method most in demand by the community. Very few women avail of IUDs, while attitudes towards vasectomy remain mostly negative.

Incentives and Costs

When the programme began in 1987, RDT felt that incentives played a part in encouraging people to adopt family planning, especially in compensating for the loss in earnings as a result of work days foregone. In addition to the government incentive, the NGO, therefore, provided one month's provisions (ragi, rice and dal), steel utensils and transport to and from the centre. These incentives were offered in the project area to acceptors in both RDT centres as well as in the government PHCs/hospitals. In the next three years these incentives were gradually reduced and finally withdrawn, with no marked difference in the number of women coming to RDT centres. In fact, the numbers kept increasing.

Currently, RDT spends an average of Rs. 135 on each acceptor (Rs. 70 for food and Rs. 65 for treatment), not taking into account overhead costs (infrastructure, salaries, etc.). As against this, it receives Rs. 170/acceptor from the government under the Private Practitioners' Scheme, Rs. 120 of which is given to the acceptor, and a further Rs. 10 (as per government norms) to the promoter/motivator. This leaves RDT with Rs. 40/acceptor to cover its direct costs, with the remaining Rs. 95 (70%) being met from project funds. Acceptors are provided free food and medical care during a seven day period. Any additional costs (transport, attendant's food) are borne by the acceptor.

The cash incentive in government PHCs/hospitals is Rs. 145, a part of which is expected to be used by the acceptor for travel and food. Direct costs in terms of medicines are also not likely to be high. Infrastructural costs, however, would appear to be substantially

higher, taking into account the large number of staff in government centres, as compared to RDT. A learning from RDT's experience is that a full-fledged hospital is not required for providing family planning services. The Anantapur centre consists of three godowns (storage sheds) converted into wards with the provision of electricity and water, and an old house transformed into an operation theatre. The centre also has a minimum of permanent staff (only two), with doctors and nurses supplied by the Kuderu centre and the government on admission and surgery days. With its non-hospital atmosphere, this centre has proved to be the most popular among RDT centres.

Most acceptors say that the cash incentive of Rs.120 (Rs.145 in the government PHC/hospital) plays no part in motivating them to undergo tubectomies. Often, however, at the beginning of the financial year, when government budgets are yet to be finalised and incentives are not available, acceptors are not willing to come forward. They would rather wait until such time as incentives are available. It would seem, therefore, that while the cash incentive may not be a factor in motivating acceptors, it is perceived by them to be a right due to them for accepting sterilisation.

Collaboration with Government Services

When RDT's family programme began, it was intended that both RDT and the government would be involved in motivating the community and each would refer people to their own centres. What happened, however, was that even government workers started to bring most of their cases to RDT centres. Discussions with MPHWs revealed that the main reason for their - and the acceptor's - preference for the RDT centre was the seven day stay which was not possible in the PHC. For the MPHWs, this reduced their burden of responsibility in ensuring the well-being of patients until their sutures were removed. In the case of the government hospital where there are many doctors and nurses, another reason could be that there is nobody the patient can perceive as 'permanent', who will respond to her post-operative complaints after she leaves.

Until recently, the district administration insisted on individual targets for all those involved in motivating the community at the grass root level to adopt family planning. The ensuing conflicts over targets made it impossible for any real collaboration to take place between RDT and the government in motivating the community, and the NGO's emphasis shifted to providing services. Recently, however, there has been a change in policy and, as a result, both RDT and the government workers at the village, sub-centre and mandal levels have been working in increasingly close collaboration to jointly motivate the community. The emphasis now is on group motivation rather than on individual targets.

CHAPTER IV

FINDINGS & DISCUSSION

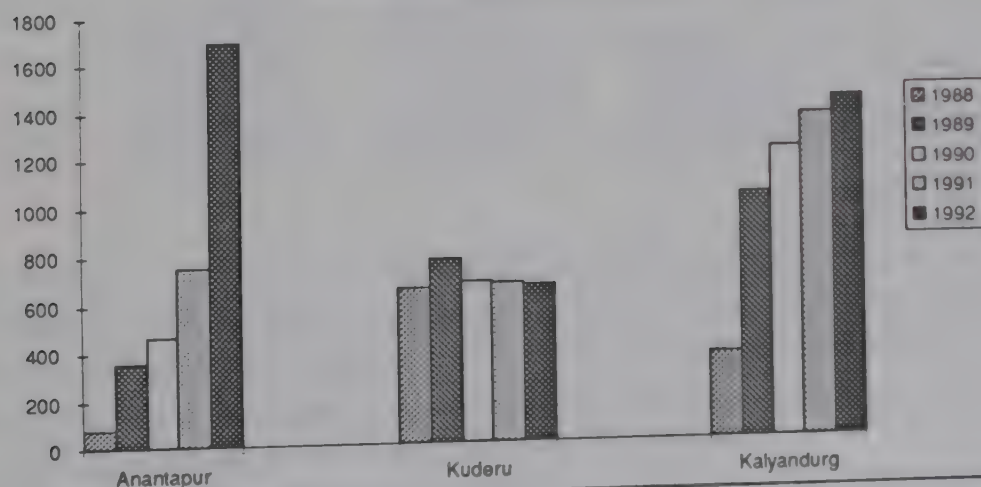
1. Trends in Usage

Number of Acceptors

An increasing number of women have been coming forward for voluntary sterilisation (tubectomy) since RDT started providing family planning services in its three centres. The number of acceptors grew more than threefold over a five year period, from 1092 in 1988 to 3777 in 1992. (Fig 1 below and Annex-Table 1). The total number of sterilisations performed in Anantapur district as a whole was also on the increase from 1990-91, but the rate of growth in RDT centres was considerably higher (33% as compared to 18% during the period 1991-92 and 1992-93).

The Anantapur centre in particular was responsible for most of this growth, especially in 1992 (when it accounted for 45% of total acceptors), and the trend continued in 1993. Some of the reasons for this growth (as compared to other RDT centres which have witnessed more moderate growth) may be its location in the catchment area of several PHCs, easier access in terms of public transport facilities, as also, the "non-hospital" atmosphere of the centre, which is perceived by acceptors as "home-like". Being situated in the town of Anantapur is also a factor, but not the most important, since government facilities in the town do not attract the same kind of numbers.

Fig. 1. No. of Acceptors, 1988-92



* 'Acceptor' means an acceptor of tubectomy in an RDT centre

RDT's Share in District Performance

RDT centres draw acceptors from the catchment area of around 27 government centres (PHCs and hospitals), with the average distance traveled by acceptors to these centres being 23 km (a few travel even 50km or more).

RDT's share in the district's total achievement against target has been increasing every year (Table 1 below). The three RDT centres performed 3976 tubectomies between April 1992 and March 1993, as against 17753 in around 34 government centres (PHCs/hospitals) in the whole district. On the average, therefore, each RDT centre had almost three times as many cases as a government centre. In Kalyandurg, when the RDT centre started, the number of acceptors in the government hospital fell initially (1988-89), then subsequently increased steadily. But it was still less than half the number in the RDT centre in 1993, and for the period as a whole (1988-93), the number of tubectomies in the Kalyandurg RDT centre was more than five times the number in the local government hospital.

TABLE 1. RDT's Share of Sterilisations Performed in Anantapur District, 1988-93

Year Apr-Mar	ANANTAPUR DISTRICT					RDT Tubectomy (as % of Total)
	Eligible Couples	Steril. Target	No. of Tub.	No. of Vas.	Total (Tub +Vas) (as % of Target)	
1988-89	467339	28560	16739	76	58.9	9.6
1989-90	483982	30300	16880	57	55.9	12.8
1990-91	511901	30000	15711	37	52.5	15.0
1991-92	512724	29000	18413	48	63.7	16.2
1992-93	N.A.	29000	21729	51	75.1	18.3

Couple Protection Rate

The proportion of eligible couples effectively protected by permanent methods in 77 villages in the RDT project area increased substantially between 1987 and 1993 from 32.4% to 42.8%. In the district as a whole, the couple protection rate (CPR) for permanent methods was lower, at 37.1%, as of end June 1993. (The overall CPR, including temporary methods, was 48.7%). As of end March 1991, the comparable state and all India CPR (permanent methods) figures were 35.6% and 30.3%, respectively (FP Yearbook, 1991).

2. Profile of Acceptors

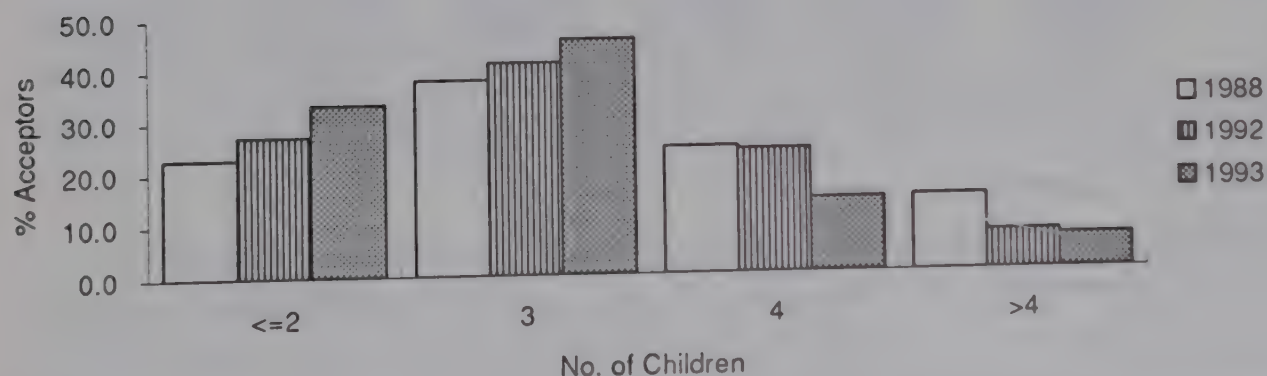
Age of Acceptors

The mean age of acceptors decreased from 27.4 years in 1988 to 26.7 in 1992. As compared to this the mean age at the state and all-India levels was 28.0 and 29.7, respectively, in 1989-90 (FP Yearbook, 1991). In the 1993 survey, 73% of acceptors were below 26 years and the mean age was 23.8. The mean age at marriage was 15 years (17.3 in the state as per the 1991 Census) - an average gap of 8.8 years between marriage and tubectomy - which indicates the likelihood of desired family size having already been achieved before the decision to have a tubectomy was taken.

Parity (No of live births per acceptor)

Since 1988, when RDT started providing family planning services, there has been a marked decrease in the number of children of tubectomy acceptors. The proportion with three children or less increased from 61% to 69% between 1988 and 1992, and was 79% in the 1993 survey (Fig 2 below). It was 71% for the state as a whole and 65% all India in 1989-90 (FP Yearbook, 1991). There was a significant increase in the proportion of acceptors with two children or less and a corresponding (even more significant) decrease in that with more than four children, during the same period.

Fig. 2. Distribution of Acceptors by No. of Children 1988,92 & 93

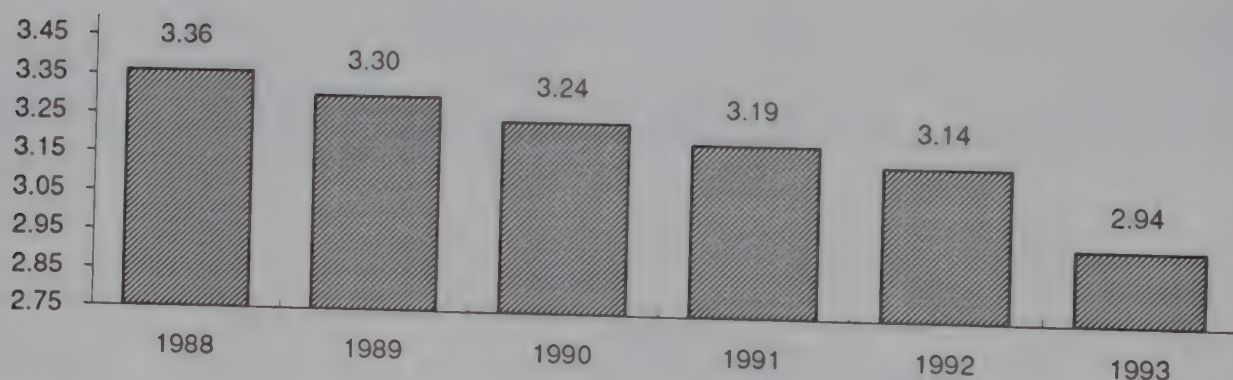


- * 'Number of children' is the same as number of living children.
- * Findings for the period 1988-92 are based on data from RDT case sheets of 12137 acceptors over the five year period.
- * Findings for 1993 are based on data from the RDT survey of acceptors (104) and non-acceptors (99) during the period Aug-Sep 1993.

Comparing 1992 data and survey data of 1993, the proportion with two children or less was higher in 1993, but that with more than four children was only marginally lower. The 1993 figure of 33% with two children or less may also be compared against 31% for the state as a whole in 1989-90 (FP Yearbook, 1991). Since the sample size used in the 1993 survey was relatively small (as compared to the data for 1988-92), further study is required to ascertain whether the survey results are indicative of a lasting trend. It is, however, clear, that acceptors are increasingly moving in the direction of smaller family size.

That there has been a consistent decrease in mean parity among acceptors is evident from Fig 3 below (also Annex-Table 3). The RDT mean was 3.36 in 1988 as compared to 3.1 for the state and 3.3 all India in 1989-90 (FP Yearbook, 1991). By 1992, it fell to 3.14 and in the 1993 survey it was 2.94. A comparison between the mean for acceptors (2.94) and their parents (5.25) also shows the significant decrease that has taken place over one generation.

Fig. 3. Mean No. of Children of Acceptors 1988-93



Caste

The caste profile of acceptors did not change significantly between 1988 and 1992, and was almost the same in the 1993 survey (Table 2 page 19). The Backward Castes (BCs) formed the majority, although they were a little less than the generally accepted figure of 60% in the total population. The proportion of Scheduled Castes (SCs) and Scheduled Tribes (STs) was maintained around the level of 20%. A slightly lower level (17.4%) was recorded among SC & ST acceptors in rural Anantapur in 1981 (Reddy, 1988).

When compared to the caste profile of the total population, the proportion of SC acceptors was slightly lower, while that of STs was higher. In the RDT target area SCs form 16.9% and STs 4.7% of total population, as compared to 15.9% SCs and 4.1% STs in rural

Anantapur district (1991 Census). The proportion of Muslim acceptors (included under Forward Castes - FCs) was 7% in 1992 and 6% in the 1993 survey, as compared to 7.9% for rural Anantapur district in 1981 (Reddy, 1988).

TABLE 2. Distribution of Acceptors by Caste, 1988, 1992, 1993 (%)

Year	SC	ST	BC	FC	Total No.
1988	14.3	6.0	51.0	28.7	1092
1992	13.4	6.3	53.8	26.5	3777
1993	13.3	5.7	56.2	24.8	104

Education

The majority of acceptors were illiterate, and while the proportion fell significantly from 1988 to 1992, the 1993 survey figure was slightly higher than in 1992 (Table 3 below). A similar figure (82.3%) was recorded in 1981 among sterilisation acceptors in rural Anantapur district (Reddy, 1988). This is slightly higher than the total proportion of illiterate women in rural Anantapur district (79% according to the 1991 Census). The RDT figure was, however, considerably higher than the state and national figures of 55.1% and 43.8% illiterate acceptors respectively in 1989-90 (FP Yearbook, 1991).

A comparison between acceptors and non-acceptors, however, showed that while the majority were illiterate in both cases, the proportion was higher among non-acceptors (93% as compared to 84%).

TABLE 3. Distribution of Acceptors by Education, 1988, 1992, 1993 (%)

Year	Illiterate	Class 1-5	Class 6-7	Class 8 & Above	Total No.
1988	85.9	6.9	4.0	3.2	1092
1992	82.2 (p<0.01)	9.1	3.7	5.0	3777
1993	83.8	9.5	4.8	1.9	104

- * 'Non-acceptor' means a non-acceptor of tubectomy from RDT villages with four or more living children, the last child being more than a year old.

Occupation

The profile of acceptors in terms of occupation was as expected, with the majority earning their livelihood from the land: farmers (18%), agricultural labourers with small land-holdings (37%) and landless labourers (16%). The category of 21% housewives consisted largely of wives of big farmers, and to a smaller extent those whose husbands were in service (mainly government jobs) or small business.

Summary

Overall, the socio-economic profile of acceptors (caste, education and occupation) generally reflected that of the population in the project and catchment areas. The mean age of acceptors was lower than the state or all India levels, while mean parity appeared to be nearing these levels. The proportion of illiterate women was higher than the national average among acceptors, but was close to the rural rate of female illiteracy in the district as a whole. In terms of caste, the BCs formed the majority, as was the case in the overall population, followed by the FCs.

3. Influence of Caste, Education and Occupation

It is widely accepted that education of women is an important factor influencing family planning usage and behaviour. Similarly, caste and occupation as determinants of socio-economic status are also likely to be influencing factors. This section examines the influence of caste, education and occupation on age of acceptors and number of children.

Caste and Number of Children

The association between caste and number of children is apparent from Fig 4 below, with the mean lowest among FCs and highest among STs and SCs. Between 1988 and 1992, mean parity decreased among all castes (see also Annex-Table 4). This trend continued in 1993 (Table 4 page 21). The lack of association found (between caste and parity) in the 1993 survey seems to indicate a general move towards smaller family size across all castes.

Fig. 4. Mean No. of Children by Caste of Acceptor 1988 & 1992

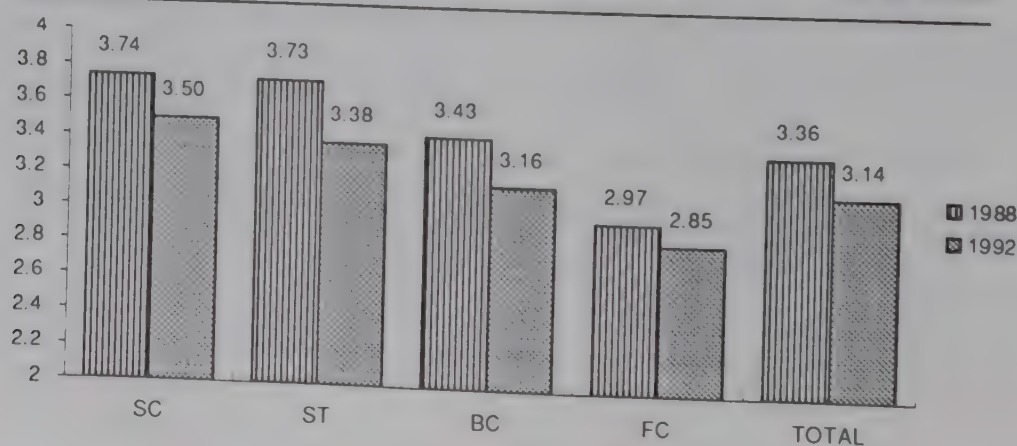


TABLE 4. Mean No. of Children by Caste of Acceptors, 1993

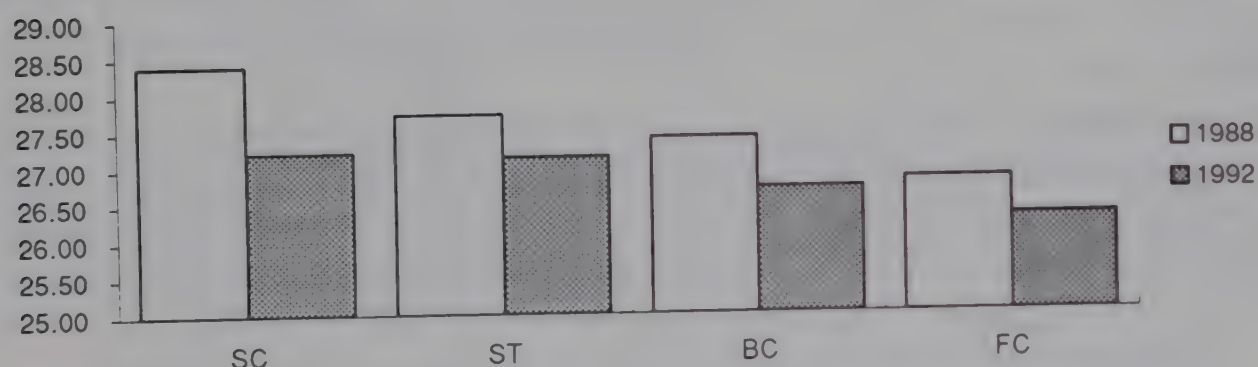
	SC	ST	BC	FC	Total
Mean	3.00	3.17	2.95	2.85	2.94
St.Dev	1.0	1.2	0.8	1.2	1.0

(See also Annex-Tables 5 and 6 for similar findings in regard to the distribution of acceptors by caste and number of children.)

Caste and Age of Acceptors

The mean age of acceptors fell overall and among all castes between 1988 and 1992 (Fig 5 below and Annex-Table 7). Mean age among acceptors surveyed in 1993 was considerably lower (than 1992) across castes (Table 5 below). (See Section on Profile of Acceptors in this chapter for a partial explanation of this difference)

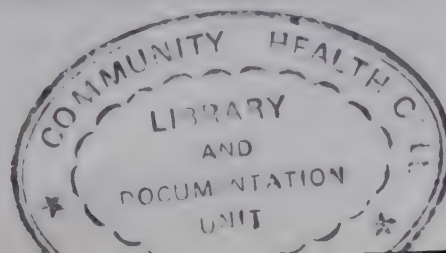
Both in 1988 and 1992, mean age was significantly different among different castes. In 1993, however, there was no significant difference, again showing perhaps a move towards more uniform behaviour, irrespective of caste.

Fig 5. Mean Age of Acceptors by Caste, 1988 & 1992**TABLE 5. Mean Age at Marriage & Operation by Caste of Acceptor, 1993**

	SC	ST	BC	FC	Total
Mean Age at Marriage*	13.71	12.50	15.19	15.89	15.00
St.Dev	1.98	1.05	1.50	2.61	2.05
Mean Age at Operation	23.29	21.83	23.98	24.12	23.80
St.Dev	3.00	3.92	2.84	3.37	3.07

(*p<0.01)

03247
WH 1/85



The average gap between age at marriage and operation (tubectomy) was more than eight years for all castes (Table 5 page 21), which means that in spite of the relatively low age at which women had tubectomies, desired family size had normally been completed.

Noorambi lives in Allapuram village near Kalyandurg. She is a muslim and was married at 15. Her first child was born a year later followed by another in quick succession. Both children were boys. "My mother urged me to have an operation after the second son, but I was afraid." Noorambi had seen her cousin develop frequent and excessive bleeding following a tubectomy operation.

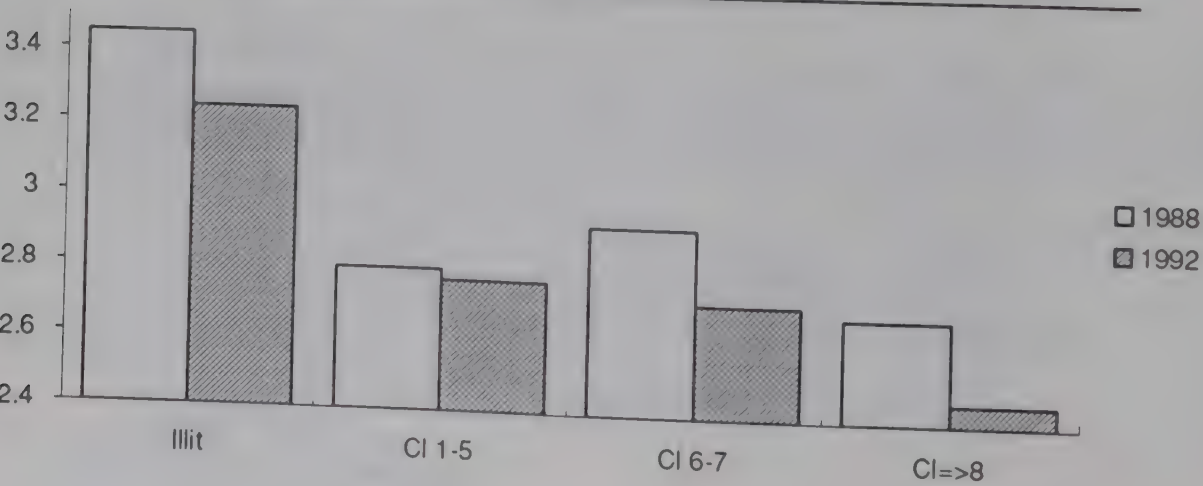
However, following the birth of a daughter three years ago she went in for a tubectomy. By the age of 22, and within seven years of her marriage, Noorambi had completed her family. Why did she not try and space her children? "Most of my relatives have done the same — have the children quickly and then go in for the operation," she says.

Education and Number of Children

Over the period 1988-92, the majority of acceptors at all levels of education had three children or less, the proportion increasing with a rise in the level of education. The number of children was found to be associated with the level of education of acceptors and their spouses, separately and as a couple (Table 6 page 23). In the 1993 survey, the proportion of acceptors with three children or less was even higher (more than 75%) at all levels of education. There was, however, no association between education and parity. (Refer Annex-Tables 8-11).

Between 1988 and 1992, mean parity fell at all education levels, but significantly only among the illiterate (Fig 6 below and Annex-Table 12). Mean parity differed significantly among different education levels. Among acceptors surveyed in 1993, mean parity was lower (as compared to 1992 data) at all education levels except Class 1-5, but there was no significant difference among different education levels (Table 7 page 23).

Fig 6. Mean No. of Children by Education of Acceptor, 1988 & 1992



In regard to the couple, there was a significant difference in the mean number of children when only the acceptor was literate, as compared to when only the spouse was literate (Table 6 below).

TABLE 6. Mean No. of Children by Education of both Acceptor & Spouse, 1988-92

1988-92	Both illiterate	Acceptor Illit Spouse Lit	Acceptor Lit Spouse Illit	Both Literate
Mean	3.38	3.14*	2.94*	2.74
St.Dev	1.0	1.0	0.8	0.8

(*p<0.01)

(N=12137)

TABLE 7. Mean No. of Children by Education of Acceptor, 1993

	Illiterate	CI 1-5	CI 6-7	CI=>8	Total
Mean	3.00	2.90	2.60	1.50	2.94
St.Dev	1.0	0.9	0.5	0.7	1.0

(N=104)

Education and Age of Acceptors

As with number of children, education was also found to be associated with age of acceptors (Fig 7 page 24 and Annex-Table 13) and, between 1988 and 1992, the mean age of acceptors fell at almost all levels of education. In 1993 (Table 8 page 24), mean age of acceptors surveyed was generally lower but, there was wide dispersion and no clear pattern emerged in relation to education.

Mean age at marriage was not found to differ significantly among different education levels (unlike in the case of caste). The wide dispersion observed in the Class 8 & above category confirms this (Table 8). With regard to the gap between marriage and operation (tubectomy), while the average was eight years, it decreased as the level of education increased, and at the highest level (Class 8 & above), it was only three and a half years. But again, given the wide dispersion, no clear inference is possible, except that it would appear that even among the most educated, women preferred to have a tubectomy once they had completed desired family size, rather than use any spacing method.

Fig 7. Mean Age of Acceptors by Education, 1988 & 92

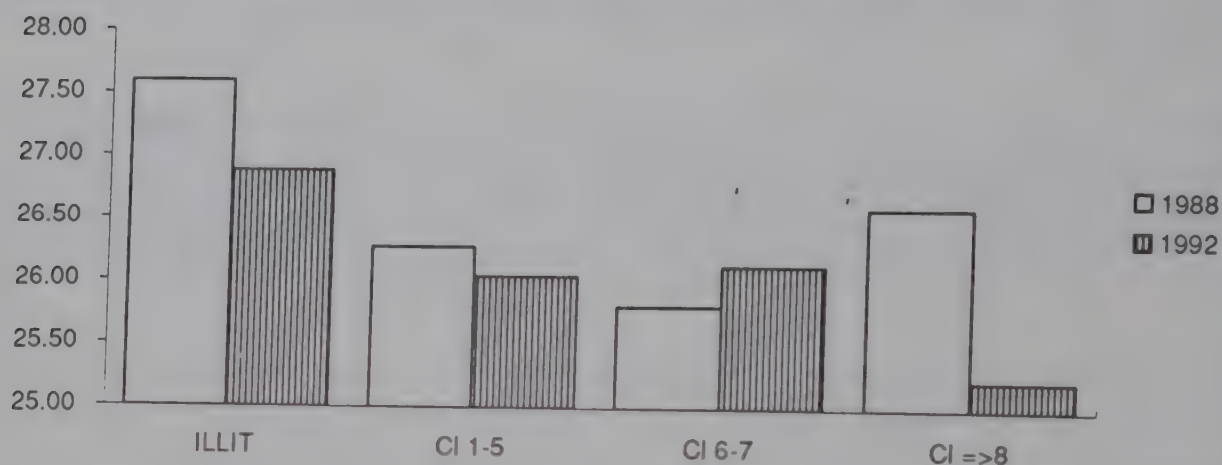


TABLE 8. Mean Age at Marriage & Operation by Education of Acceptor, 1993

	Illiterate	CI 1-5	CI 6-7	CI =>8	Total
Mean Age at Marriage	14.84	15.80	15.80	16.50	15.00
St.Dev	1.90	2.66	1.30	6.36	2.05
Mean Age at Operation	23.84	24.70	22.80	20.00	23.80
St.Dev	3.00	3.92	2.84	3.37	3.07

Occupation (1993 Survey)

No association was found between occupation of acceptor (or spouse) and number of children; nor was there any significant difference in mean number of children among different occupational categories (Table 9 below).

TABLE 9. Mean No. of Children by Occupation of Acceptors, 1993

	Agri Farmer	Agri Labour	Land-less	Busi-ness	Ser-vice	House-wife
Mean	2.79	2.87	3.06	2.50	2.67	3.23
Std.Dev	0.9	0.8	1.1	0.7	0.5	0.2
% Cases	18.1	37.1	16.2	1.9	5.7	21.0

(N=104)

Summary

Between 1988 and 1992, the mean age and number of children of acceptors fell among all castes and at all education levels. The expected association between caste, education and acceptors' age and family size was found in RDT data for the five year period 1988-92, but not in survey data for 1993. The lack of association with either caste, education or occupation in 1993 survey findings seems to indicate that irrespective of these factors, there is a general trend towards smaller family size (three children or less) and, in keeping with this, a lower mean age among acceptors. This is to some extent reflected in the opinions expressed by the majority of acceptors with regard to an ideal family size of two children (1M+1F) (see Section 6 page 28).

The influence of education (of acceptor and spouse) on family size was clearly evident from RDT data for the five year period 1988-92. The importance of the wife's education, in particular, was also borne out. The 1993 survey findings, however, showed no significant difference in age or family size among different education levels - the equalising factor may have been a general increase in awareness among illiterate acceptors rather than education in the formal sense.

It is necessary to keep in mind, however, the fact that the sample size used in the 1993 survey was relatively small (as compared to the data for 1988-92), and, therefore, further study is required to ascertain whether the survey results are representative of a real/lasting trend. It is, however, clear, that acceptors are increasingly moving in the direction of smaller family size (and lower age at acceptance).

4. Knowledge and Usage of Family Planning (1993 Survey)

Responses to questions regarding knowledge and usage of family planning were difficult to get: in many instances, even after in-depth probing there was denial of any knowledge about the various methods (apart from tubectomy, of course), even though according to RDT's experience and knowledge of the community, there is considerable awareness on the subject. All India, however, Andhra Pradesh rated among the lowest in terms of awareness of temporary methods in 1988 (ORG,1990). The results with regard to usage may more closely reflect reality, as RDT's experience also confirms the lack of acceptance among the community of temporary methods. There is almost a complete rejection of vasectomy as it is believed to have extremely harmful post-operative consequences for the husband who as the bread-winner in the family cannot, in the popular perception, be permitted to lose his strength.

Surprisingly, both knowledge and usage of temporary family planning methods were found to be higher among non-acceptors as compared to acceptors. Also, more non-acceptors mentioned government workers as their primary source of information, while among

acceptors, neighbours/relatives played a greater role (Tables 10 & 11 below). No association was found between knowledge about FP methods and either caste or education of acceptors (or non-acceptors).

TABLE 10. Knowledge and Usage of FP among Acceptors, 1993 (%)

Method	Knowledge	Source Of Knowledge					Usage
	Yes	Don't Know	Govt. Worker	Neighbour	Relative	Acceptor	Yes
Oral Pills	48.1	16.0	12.0	50.0	6.0	16.0	3.8
Condom	13.5	35.7	7.1	14.3	28.6	14.3	0.0
Copper T	44.2	23.9	13.0	34.8	17.4	10.9	1.9
Vasectomy	63.5	69.7	0.0	13.6	9.1	7.6	1.0

(N=104)

TABLE 11. Knowledge and Usage of FP among Non-acceptors, 1993 (%)

Method	Knowledge	Source Of Knowledge					Usage
	Yes	Don't Know	Govt. Worker	CHW	Relative	Others	Yes
Oral Pills	71.7	2.1	47.9	26.6	5.3	18.1	23.2
Condom	36.4	2.9	40.0	5.7	8.6	42.9	3.0
Copper T	60.6	3.4	64.4	3.4	3.4	25.4	11.1
Permanent	95.0	2.4	49.4	0.0	18.8	29.4	0.0

(N=99)

5. Decision to have a Tubectomy (1993 Survey)

The decision to have a tubectomy was most often a joint decision (48% of cases); when made singly it was made more often by the spouse (23%) than the acceptor (18%); and in 11% of cases it was decided by close relatives. The majority of acceptors (69%) came from nuclear families which may explain why in 89% of cases the decision was made by the couple (singly or together).

Reasons for deciding to have a tubectomy fell into three broad categories:

1. (50%) Better care for children (good food, education, etc.)
2. (9%) Enough children to satisfy economic needs (as "working hands" and for security in old age)

3. (41%) Enough sons/daughters (enough sons/too many daughters).

No association was found between caste or education and reason for having a tubectomy. There was, however, an association with number of children: as the number increased, as expected, the responses shifted from category 1 to 3 (above).

Reasons for Non-acceptance	%
1. Waiting for a son	43.4
2. Waiting for a daughter	3.0
3. Fear in relation to survival of children	11.1
4. Needing more hands to work	13.1
5. Need for security in old age	5.1
6. Fear of operation	36.4
7. Ill-health of mother	21.1
8. * Planning to have tubectomy	46.5

(N=99)

(Due to multiple responses, total exceeds 100%)

(*Category 8 responses represent non-acceptors who are potential acceptors).

Yellakka, 38, lives in Yerragunta village which has several hundred households. She belongs to the scheduled caste community and lives in a nuclear family with her husband Chowdappa and four sons — the eldest being nine years old and the youngest 18 months.

Yellakka has resisted all efforts by RDT staff and fellow villagers to go in for a tubectomy. "I want to have a daughter," she says "Having a daughter is important for me as only daughters really care for their parents." Most of Yellakka's neighbours think she is crazy. "In such hard times everyone is thinking of fewer children and you are going on and on." You must stop," says one. But Yellakka shrugs off such criticism. "God will give us help to bring up our children."

The most commonly cited reasons, in general, for non-acceptance of family planning have been found to be economic (security in old age, more working hands), fear in regard to survival of children, and the almost universal desire for sons. The survey findings were broadly similar, except that waiting for a son was the most often cited reason for non-acceptance, followed by fear of the operation. Fear about survival of children and needing more working hands were, in fact, not found to be a major reason. Conversely, among acceptors, the two main reasons for accepting sterilisation were that they could take better care of their children and that they had enough sons (or did not want another daughter). As many as 47% of non-acceptors (category 8 above) were actually potential acceptors who

were planning to have tubectomies, and the major reason (63% of cases) for delay among them was that they were waiting to have a son.

6. Desire for a Son and Ideal Number of Children

Desire for a Son

The desire for a son is reflected in almost every aspect of the data. Acceptors without a female child were four times as many as those without a male child in both 1988 and 1992. Even among the FCs, the proportion without a female child was high, and increased from 1988 to 1992 (Table 12 below). Among acceptors with two children or less (1988-92), as many as 43% had no female child, while only 6% had no male child (Table 13 below).

TABLE 12. Acceptors without a Son/Daughter by Caste, 1988 & 1992

	% Without Son					% Without Daughter					Total
	SC	ST	BC	FC	TOTAL	SC	ST	BC	FC	TOTAL	Cases
1988	1.9	0.0	2.9	7.3	3.8	9.6	18.2	16.5	8.8	16.3	1092
1992	2.4	2.5	2.8	6.8	3.8	11.7	13.0	19.1	19.5	17.8	3777

TABLE 13. Acceptors Without a Son/Daughter by No. of Children, 1988 - 92

No. of Children	<=2	3	4	>4	Total
% Without Son	6.0	3.1	2.1	2.0	3.5
% Without Daughter	42.6	2.8	4.4	1.8	16.8

(N=12137)

Ideal Number of Children

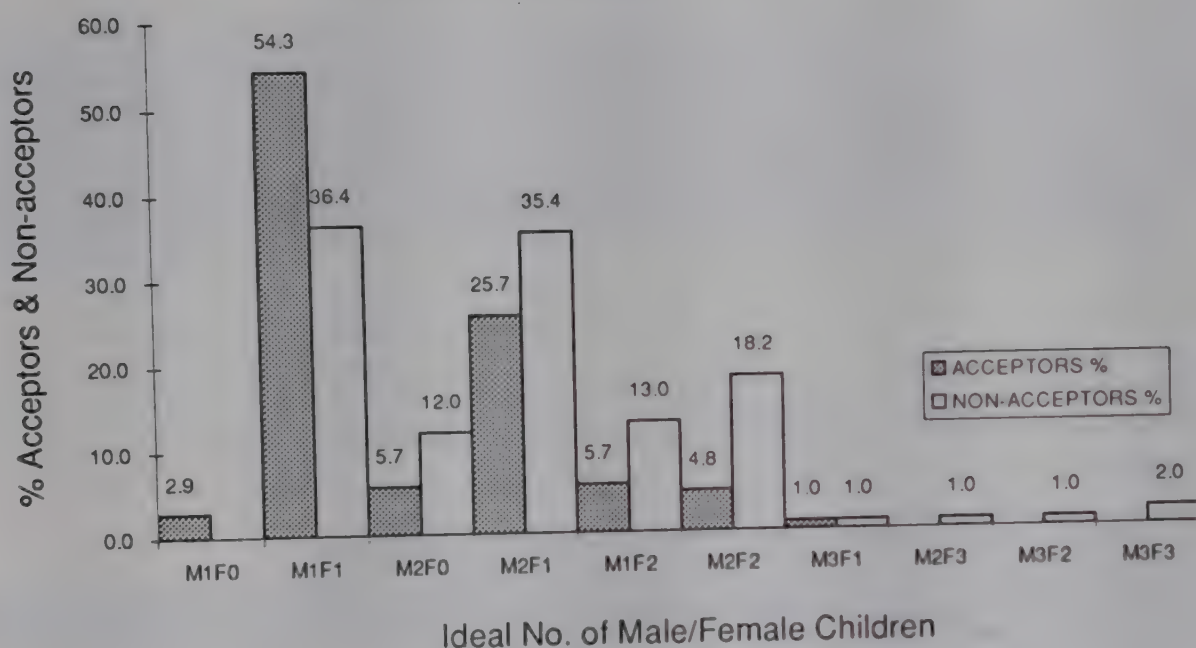
The majority of acceptors (60%) felt that two children (1Male+1Female) was the ideal family size. Among non-acceptors, an equal number (38% each) opted for two (1M+1F) and three (2M+1F) children as the ideal. In the case of both (acceptors and non-acceptors), there was no combination (of M/F children) with less than one son, although the desire for two sons was found to be less among acceptors. Only among acceptors was there fair agreement between the ideal and actual number of children. It would seem that the observed gap between the ideal and actual number of children in the case of acceptors is because of the almost universal desire to have a son (Fig 8 and Annex-Table 14).

Mallakka is illiterate and belongs to Allapuram village. She and her husband Yellappa belong to a backward caste. They own five acres of wet and one acre of dry land which places them among the economic middle class in the village.

About a year ago, Mallakka underwent a tubectomy at RDT following the birth of her second son. According to her, the first son being dumb her father persuaded her not to stop trying until she had a 'normal' son. "In the process we had three girls in a row," she says. "I would have stopped at two children if my first son had been normal."

Fig 8. Distribution of Acceptors and Non-acceptors by Opinion on Ideal No. of

Male/Female Children, 1993



7. Decision to use RDT Family Planning Facilities

The quality of services provided at RDT centres seems to be the major reason why people come to these centres, mostly on the recommendation of previous acceptors or relatives, but also at the suggestion of RDT staff and government health workers (Table 14 page 30). This is clear from the overwhelming response of acceptors that good treatment/facilities and confidence in the services was their main reason for choosing to come to RDT. Their perception of RDT facilities also confirms this (Table 16 page 30).

TABLE 14. Source of Knowledge about RDT FP Facilities, 1993 (%)

Centre	Source Of Knowledge			
	Previous Acceptor	Govt. Worker	Relative	RDT Staff /CHW
Anantapur	50.0	14.7	14.7	20.6
Kalyandurg	28.9	15.8	28.9	26.3
Kuderu	34.4	18.8	28.1	18.8
Total	37.5	16.3	24.0	22.2

(N=104)

TABLE 15. Reasons for Using RDT FP Facilities, 1993 (%)

Centre	Quality Of Service				Near To Village	Free Service
	Confidence In Service	Good Facilities	Good Treatment	All Three Factors		
Anantapur	0.0	11.8	32.4	52.9	2.9	0.0
Kalyandurg	5.3	13.2	52.6	28.9	0.0	0.0
Kuderu	0.0	6.3	9.4	62.5	18.8	3.1
Total	1.9	10.6	32.7	47.1	6.7	1.0

(N=104)

TABLE 16. Acceptors' Perception of RDT Facilities, 1993 (%)

	Anantapur	Kalyandurg	Kuderu	Total
Good Facilities/Treatment	97.1	92.1	93.8	94.2
Free Service	2.9	7.9	6.3	5.8

(N=104)

As discussed in the earlier chapter, the seven days of post-operative care, including food and medicine, is an important factor in influencing the community's and motivators' (largely government workers) choice of RDT centres. Given that most acceptors come soon after delivery, the seven days also serves as a post-natal recovery period. Acceptors' willingness to travel long distances to these centres also indicates that accessibility is not necessarily a constraint and quality of service is perceived as more important. The

mean distance traveled by acceptors to RDT centres was 23 km: Anantapur 26km, Kalyandurg 24km, Kuderu 18km. Distances over 5 km are generally considered by village women as a disincentive for availing FP services (see ORG, 1990).

It is unlikely that incentives influence choice: the withdrawal of additional incentives which were provided in the initial years (see Page 12 Chapter III) had no effect on the number of acceptors coming to RDT centres, and responses of acceptors surveyed also indicate that quality of service is the major reason for their choice. While the incentive given in RDT centres (Rs.120) is lower than in the government centres (Rs. 145), acceptors in government centres are expected to use part of this for food, and sometimes also for medicines. Overall, it would appear, that incentives are not a major factor influencing the decision to have a tubectomy, or the choice of centre. At the same time they are perceived as a right due to the acceptor.

It is perhaps necessary to distinguish between incentives in the nature of "compensation" for earnings lost and expenses incurred - which are what are perceived as rightfully due to the acceptor - and other kinds of incentives. In the latter case, the nature and size of the incentive makes a difference. Incentives such as utensils and provisions do not seem to have any influence (as evident from RDT's experience), but when plots of land are offered they may act as a real incentive, depending to what extent people feel such offers will be actually followed up.

8. Limitations of Study

The scope of the study was to a large extent determined by the data available and the constraints of time, staff and resources. For instance, data on income of acceptors was not available from RDT records, and given the unreliability of responses in regard to income when using a questionnaire, it was decided not to include it in the survey questionnaire. Instead, it was felt that caste data which is available and data on occupation (from the survey) could provide a proxy for income/socio-economic status. Responses to questions regarding knowledge and usage of family planning were difficult to get, in spite of their being posed by women survey team members, as acceptors were reluctant to talk about the subject.

An area which was not taken up for study was the cost effectiveness of RDT's family planning services. While this is of importance in assessing the overall effectiveness of the programme, it was felt that it would require a separate study by itself and it would, therefore, not be appropriate nor feasible to deal with it in the present study.

CHAPTER V

CONCLUSIONS & RECOMMENDATIONS - A SUMMARY

This chapter summarises some of the major findings of the study both as a learning for RDT and in terms of their implications at the macro-level.

Increase in Family Planning Usage

An increasing number of women have been coming forward for voluntary sterilisation (tubectomy) since RDT started providing family planning services in response to community demand. The rate of growth in the number of tubectomies performed in RDT centres has been considerably higher than in the district as a whole. The proportion of eligible couples effectively protected is also higher in the RDT project area as compared to the district overall.

Quality of Service

Quality of services seems to be the key to increasing family planning usage among the community. While accessibility is important, quality of care, treatment and facilities is perceived as even more important. Greater emphasis needs, therefore, to be placed on improving and upgrading existing FP facilities.

Decrease in Mean Parity

There has been a consistent decrease in mean parity (number of live births per acceptor) among RDT acceptors since 1988, among all castes and at all education levels. It is clear that there has been a gradual shift towards fewer children, reflecting increasing acceptance of the small family norm.

Lower Age of Acceptors

The experience in RDT is that increasingly younger women are coming forward for sterilisation. But, given the early age at marriage and the poor use of spacing methods, in practice most women have already had the desired number of children by the time they come for tubectomies. The increasingly lower age of acceptors is, therefore, more a matter of concern rather than a positive sign.

Lack of Real Choices

The fact that women perceive sterilisation as the only method (which is safe, effective and available) probably indicates a lack of real alternatives, rather than a situation in which

they are making an informed choice. While temporary methods are available, they are not felt to be either safe or effective, although there is no evidence to suggest that improving access to and information on temporary methods would make these women choose them over sterilisation. More concerted efforts however need to be made to increase knowledge about temporary methods and promote their use. But this cannot be achieved in isolation, without measures aimed at improving the overall health of women, raising the age at marriage and changing attitudes and perceptions in the community.

Increasing Men's Involvement

The rejection of vasectomy because of its perceived physical ill-effects and of condoms because they are socially unacceptable means that the burden of regulating family size lies entirely on women. At the same time while women bear the entire responsibility they are seldom the decision takers. There is a need for measures aimed at improving knowledge and changing perceptions of such methods among the community, and more effectively including men within the family planning programme.

Empowering Women

The gap between ideal and actual family size among acceptors, as well as among non-acceptors, is to a large extent related to the desire for a son. This indicates the need for an integrated approach which aims at raising education and awareness levels among men and women, and improving the overall status of women, rather than focusing on family planning alone.

Incentives

Incentives in the form of compensation to cover wages lost and expenses incurred are perceived as a right by acceptors. At the same time, they do not seem to be the decisive factor in determining acceptance of family planning. The rationale for giving these incentives, of different types and magnitude, needs to be reconsidered in the light of their efficacy and cost-effectiveness.

Cost Effectiveness

An issue that RDT needs to address in the near future is the cost-effectiveness of its family planning programme, as the demand for its services continues to grow. This is also a matter to be examined in the context of government facilities, given the large infrastructure and poor utilisation of services.

ANNEXURE

ANNEX-TABLE 1. NUMBER OF ACCEPTORS (1988-92)

YEAR	ANANTAPUR	KUDERU	KALYANDURG	ALL
1988	78	649	365	1092
%	7.1	59.4	33.4	9.0
1989	350	768	1032	2150
%	16.3	35.7	48.0	17.7
1990	460	673	1217	2350
%	19.6	28.6	51.8	19.4
1991	743	665	1360	2768
%	26.8	24.0	49.1	22.8
1992	1690	659	1428	3777
%	44.7	17.4	37.8	31.1
Total	3321	3414	5402	12137
%	27.4	28.1	44.5	

ANNEX-TABLE 2. DISTRIBUTION OF ACCEPTORS BY NO. OF CHILDREN 1988, 92 & 93

Year	No. of Children				Total
	≤2	3	4	>4	
1988	22.9	38.1	24.5	14.6	1092
1992	27.2	41.3	23.9	7.6	3777
1993	33.3	45.7	14.3	6.7	104

(1988 & 92) Chi-Square = 52.53 P= 0.0000

ANNEX-TABLE 3. MEAN NUMBER OF CHILDREN BY CENTRE (1988-1993)

Year	ALL CENTRES		ANANTAPUR		KALYANDURG		KUDERU	
	MEAN	ST.DV	MEAN	ST.DV	MEAN	ST.DV	MEAN	ST.DV
1988	3.36	1.15	3.14	1.02	3.41	1.03	3.36	1.22
1989	3.30	1.03	3.27	0.97	3.35	1.02	3.26	1.06
1990	3.24	0.95	3.10	0.93	3.34	0.95	3.16	0.94
1991	3.19	0.97	3.08	0.92	3.31	0.99	3.06	0.92
1992	3.14	0.97	3.03	0.93	3.30	1.01	3.04	0.92
1988-92	3.22	1.00	3.08	0.93	3.33	0.99	3.18	1.02
1993	2.94	0.96						

1988 & 92 (All Centres): $z=5.8$, $p<0.1$

ANNEX-TABLE 4. MEAN NUMBER OF CHILDREN BY CASTE OF ACCEPTOR (1988 & 1992)

	SC	ST	BC	FC	TOTAL	
1988 MEAN	3.74	3.73	3.43	2.97	3.36	F=21.72
ST.DEV	1.3	1.3	1.1	1.0	1.2	p=0.000
1992 MEAN	3.50	3.38	3.16	2.85	3.14	F=59.60
ST.DEV	1.1	1.0	0.9	0.9	1.0	p=0.000
z=	2.14	1.96	5.31	1.84	5.76	

ANNEX-TABLE 5. DISTRIBUTION OF ACCEPTORS BY CASTE & NO. OF CHILDREN (1988-92)

CASTE	NO. OF CHILDREN				TOTAL	
	≤ 2	3	4	> 4	No.	%
SC	12.3	38.3	33.2	16.1	1604	13.2
ST	16.2	38.2	29.9	15.7	662	5.5
BC	21.2	43.4	26.3	9.1	6542	53.9
FC	36.9	41.1	16.4	5.5	3329	27.4
TOTAL	24.1	41.8	24.7	9.4	12137	100.0

ANNEX-TABLE 6. DISTRIBUTION OF ACCEPTORS BY CASTE & NO.OF CHILDREN (1993)

	NUMBER OF CHILDREN				TOTAL
	<=2	3	4	>4	
SC	4	6	3	1	14
%	28.6	42.9	21.4	7.1	13.4
ST	1	2	3	0	6
%	16.7	33.3	50.0	0.0	5.8
BC	17	30	8	3	58
%	29.3	51.7	13.7	5.1	55.8
FC	13	9	1	3	25.0
%	50.0	34.6	3.8	11.5	24.76
TOTAL	35	47	15	7	104
%	33.6	45.2	14.4	6.6	

Chi-square=14.07, p=0.120

ANNEX-TABLE 7. MEAN AGE OF ACCEPTOR BY CASTE, 1988 & 1992

		SC	ST	BC	FC	TOTAL	
1988	MEAN	28.40	27.73	27.40	26.83	27.40	F=11.97
	ST.DEV	3.0	2.8	2.7	2.7	2.8	P=0.000
1992	MEAN	27.21	27.15	26.71	26.31	26.70	F=18.26
	ST.DEV	2.5	2.9	2.4	2.4	2.5	P=0.000
Z=		4.47	1.47	5.54	3.04	7.56	

ANNEX-TABLE 8. DISTRIBUTION OF ACCEPTORS BY EDUCATION OF ACCEPTOR AND SPOUSE AND NUMBER OF CHILDREN (1988-92).

NO.OF CHILD	EDUCATION OF ACCEPTOR					EDUCATION OF SPOUSE				
	Illit.	CI 1-5	CI 6-7	CI=>8	Total	Illit.	CI 1-5	CI 6-7	CI=>8	Total
<=2	19.9	35.5	40.9	56.3	24.1	18.3	26.7	29.5	42.2	24.1
3	42.1	42.7	43.3	34.7	41.8	41.9	42.6	43.8	39.9	41.8
4	27.2	17.3	12.4	7.1	24.7	28.5	23.2	20.0	13.2	24.7
>4	10.7	4.5	3.3	1.9	9.4	11.3	7.5	6.8	4.7	9.4
Total	81.7	9.4	3.7	5.1		63.2	14.0	6.9	15.9	

Chi-square=722.71, p=0.000 N=12137

Chi-square=629.92, p=0.00 N=12137

ANNEX-TABLE 9. DISTRIBUTION OF ACCEPTORS BY EDUCATION OF BOTH ACCEPTOR & SPOUSE AND NUMBER OF CHILDREN (1988-92).

EDUCATION LEVEL (% ACCEPTORS)	NO. OF CHILDREN				Total
	<=2	3	4	>4	
BOTH ILLIT	17.5	41.7	28.9	11.8	59.8
SPOUSE LIT & ACCPTR ILLIT	26.5	43.1	22.5	7.9	21.9
SPOUSE ILLIT & ACCPTR LIT	32.1	45.1	19.6	3.2	3.4
BOTH LIT	44.8	39.5	12.0	3.6	14.9

Chi-square=783.23, p=0.000

(N=12137)

ANNEX-TABLE 10. DISTRIBUTION OF ACCEPTORS BY EDUCATION OF ACCEPTOR & SPOUSE AND NO. OF CHILDREN - 1993 Survey (%)

NO. OF CHILD.	EDUCATION OF ACCEPTOR					EDUCATION OF SPOUSE				
	ILLIT	CLASS	CLASS	CLASS	TOTAL	ILLIT	CLASS	CLASS	CLASS	TOTAL
	1-5	6-7	=>8			1-5	6-7	=>8		
=<2	31.8	30.0	40.0	100.0	33.3	34.8	23.5	40.0	35.7	33.3
3	44.3	60.0	60.0	0.0	45.7	44.9	52.9	40.0	42.9	45.7
4	17.0	0.0	0.0	0.0	14.3	13.0	17.6	20.0	14.3	14.3
>4	6.8	10.0	0.0	0.0	6.7	7.2	5.9	0.0	7.1	6.7
TOTAL	83.8	9.5	4.8	1.9		65.7	16.2	4.8	13.3	

Chi-square=7.98, p=0.536

Chi-square=1.60, p=0.996

(N=104)

ANNEX-TABLE 11. DISTRIBUTION OF ACCEPTORS BY EDUCATION OF BOTH ACCEPTOR & SPOUSE AND NO. OF CHILDREN, 1993 Survey (%)

EDUCATION OF ACCEPTOR & SPOUSE	NUMBER OF CHILDREN				
	<=2	3	4	>4	TOTAL
BOTH ILLIT	32.8	45.9	14.8	6.6	58.10
SPOUSE LIT & ACCPTR ILLIT	29.6	40.7	22.2	7.4	25.71
SPOUSE ILLIT & ACCPTR LIT	50.0	37.5	0.0	12.5	7.62
BOTH LIT	33.3	66.7	0.0	0.0	8.57

Chi-square=6.57, p=0.682

(N=104)

ANNEX-TABLE 12. MEAN NO.OF CHILDREN BY EDUCATION OF ACCEPTOR, 1988 & 1992

		Illit	CI 1-5	CI 6-7	CI =>8	Total	N	
1988	MEAN	3.45	2.80	2.93	2.69	3.36	1092	F=14.39
	ST.DEV	1.2	0.9	1.1	0.9	1.2		p=0.000
1992	MEAN	3.24	2.77	2.72	2.46	3.14	3777	F=70.45
	ST.DEV	1.0	0.8	0.7	0.8	1.0		p=0.000

Z = 5.03 0.27 1.18 1.38

ANNEX-TABLE 13. MEAN AGE OF ACCEPTOR BY EDUCATION, 1988 & 92

		ILLIT	CI 1-5	CI 6-7	CI =>8	TOTAL	
1988	MEAN27.60	26.27	25.80	26.57	27.40	F=12.28	
	ST.DEV2.7	2.7	2.4	2.6	2.8	p=0.000	
1992	MEAN26.88	26.04	26.12	25.23	26.70	F=39.64	
	ST.DEV2.4	2.5	2.0	3.4	2.5	p=0.000	

Z= 7.26 0.69 0.81 2.64 7.56

ANNEX-TABLE 14. DISTRIBUTION OF ACCEPTORS & NON-ACCEPTORS BY OPINION ON IDEAL NO. OF CHILDREN, 1993

	NUMBER OF CHILDREN						No.of Cases
	1	2	3	4	5	6	
ACCEPTOR %	2.9	60.0	31.4	5.7	0.0	0.0	104
NON-ACCEPTOR %	0.0	38.4	38.4	19.2	2.0	2.0	99

REFERENCES

1. Govt. of India, Planning Commission (1992): Eighth Five Year Plan, 1992-97.
 2. Govt. of India, Registrar General and Census Commissioner: Primary Census Abstract, 1991 .
 3. Govt. of India, Ministry of Health & Family Welfare, New Delhi (1991): Yearbook - Family Welfare Programmes in India, 1990-91.
 4. Reddy, P.H., et al (1988): Health and Family Welfare Status of the Population - Final Report on the Baseline Survey, India Population Project II, Andhra Pradesh, Population Centre, Bangalore and Director of Health & Family Welfare, A.P.
 5. Operations Research Group (1990): Family Planning Practices in India, Third All India Survey Vol II.
-

ACTIONAID is an international development organisation dedicated to help children, families and communities to overcome poverty and secure lasting improvements in the quality of their lives. ACTIONAID's work is spread across 20 developing countries in Asia, Africa and Latin America.

ACTIONAID has been in India for over two decades and is today one of the largest non-governmental organisations (NGOs) working in the country. With years of experience in long-term integrated rural development, ACTIONAID India is now expanding its operations to work with the urban poor and in disaster relief. Increasingly, the grassroots-level experience is being used to influence policy-makers at the national and international levels.

ACTIONAID India works primarily in partnership with about 150 voluntary organisations spread out in 13 states of India, covering over 750,000 people who have little access to or control over resources. The focus is on the socially and economically marginalised scheduled castes, scheduled tribes and minorities. Even within these, keen attention is paid to women and children and people with disabilities.

CENTRAL OFFICE:
3, Rest House Road,
Bangalore 560 001
Tel: (080) 5586682
Fax: (080) 5586284

REGIONAL OFFICES
19, Samadhan Colony
Aurangabad 431 001
Tel & Fax: (02432) 28

3D Blessington Apts,
34, Serpentine Street
Bangalore 560 025
Tel: (080) 224 0399

E-7/73, Lajpat Society
Shahpura, Arera Colony
Bhopal 462 016
Tel: (0755) 565575

237 Jodhpur Park
Calcutta 700 068
Tel & Fax: (033) 473

Plot No. 22, Krishnapur
Colony, West Marreda
Hyderabad 500 026
Tel: (040) 804992

97, Uday Park,
New Delhi 110 049
Tel: (011) 685 6715

**REGISTERED
HEAD OFFICE:**
Hamlyn House
Archway
London N19 5PG UK

